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ABSTRACT

In recent years, increased state interest in school-based health centers has been reflected in greatly expanded financial support for the centers. However, with no apparent new sources of support for continued expansion of the centers and increased competition among community providers for existing public health dollars the further of SBHC is uncertain. This document summarizes the proceedings of a meeting between a small group of federal and state health policy makers and representatives from school-based health centers (SBHC) and managed care plans who reviewed experiences in the development of relationships between SBHC and managed care organizations. Participants considered the implications of this experience for public policies. Three perspectives on building relationships between SBHC and managed care organizations are presented: (1) school-based health center perspectives; (2) state perspectives on SBHC; (3) and a managed care perspective. In attempting to reach consensus on a series of issues fundamental to financing school-based health centers, the following topics were discussed: defining SBHC services, developing a uniform standard, funding stability and preserving the mission of SBHC, a conservative culture, challenges ahead, and critical next steps. Contains nine sources and three appendices: (1) participants roster; (2) local SBHC profiles; and (3) state SBHC profiles. (JBJ)

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STATE AND LOCAL PARTNERSHIPS TO ESTABLISH
SCHOOL-BASED HEALTH CENTERS

ED 398 504

**Medicaid, Managed Care, and School-Based Health Centers:
Proceedings of a Meeting with Policy Makers and Providers**

Monday, June 26, 1995, 8:30 am to 3:30 pm, Dupont Plaza Hotel, Washington, DC

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Medicaid, Managed Care, and School-Based Health Centers: A Dialogue among Policy Makers and Providers

"To some extent, I think school-based health centers are antithetical to managed care because school-based health care staff look for problems they can fix. They say: 'Statistics indicate that about ten percent of the kids in this school have a particular problem, 50 percent of the kids might be doing drugs, and 80 percent of the kids probably are sexually active.' But those kids have not shown up for care, so school-based health center staff go out and find them. School-based health centers are confronting problems that people would just as soon not deal with."

-- Kathleen Johnston, Memphis/Shelby County Department of Health

"Even though we've seen progress in Massachusetts, we still have a basic problem: there does not seem to be any agreement as to whether, ultimately, school-based health centers afford better or lower cost care for adolescents. And it seems like until we can reach that agreement, it will be hard to negotiate other possibilities."

-- Karen Hacker, Boston Health & Hospitals

"There are many larger providers at the same table with school-based health centers. They give the same sets of services. So, to pluck school-based health centers out and treat them differently is a problem."

-- Mary Applegate, New York State Department of Health

Background Statement

In recent years, increased state interest in school-based health centers has been reflected in greatly expanded financial support for the centers. In 1994, 25 state governments invested \$12 million of their Maternal and Child Health (MCH) block grant dollars and \$22.3 million of general fund dollars in school-based health centers, increases of 45 percent and 140 percent respectively over the preceding two years. As a result, the number of school-based health centers in the United States has doubled since 1991. By spring 1995, there were approximately 650 health centers in schools across the country.

Despite this unprecedented level of state support as well as new federal funding from the U.S. Department of Health and Human Services, school-based health centers face a difficult future.¹ MCH block grant dollars are under attack in the 104th Congress. State general funds are being used to fill in for federal cuts, and the state surpluses that eased the way for earlier school-based health center initiatives have largely disappeared. With no apparent new sources of support for continued expansion of the centers and increased competition among community providers for existing public health dollars, the future of school-based health centers is uncertain. To survive, school-based health centers and their sponsors must secure reliable sources of funding.

¹In FY1995, the DHHS Health Resources and Services Administration launched the first federal initiative to fund school-based health centers explicitly. Grants included 27 school-based health centers, 20 staff training grants and seven grants to support mental health care at the centers.

Propelled by impending limits on federal and state grant funds, school-based health centers have looked to patient care revenues as an untapped source of support. Historically, these revenues have played a small role in health center finances. National data from 1991 documented that patient revenue accounted for less than five percent of total school-based health center support. Two years later, data from 23 school-based health centers funded by The Robert Wood Johnson Foundation indicated that patient revenues had contributed 15 percent of health center costs.

Located primarily in low-income communities, which are home to large numbers of Medicaid-insured students, school-based health centers have become more aggressive in implementing billing and collection procedures. Simultaneously, however, many states have initiated Medicaid managed care programs that have complicated the process of securing payments for services to Medicaid beneficiaries.

Even the most efficient Medicaid billing operation, however, will leave many school-based health center costs uncovered. Uninsured students, services that are not reimbursable, and inadequate managed care capitation rates will all result in funding shortfalls. Securing adequate financing for school-based health centers will require more than adept administrators at the community level. The fragility of these newest members of the primary care delivery system may require policy makers to provide special protections if the centers are to survive in a market-driven environment with increasingly limited public health dollars.

Challenging dilemmas confront public officials, especially those who support both school-based health centers as a way to increase access to care and managed care as a vehicle to organize and pay for that care. Should these states ensure the survival and expansion of the centers by guaranteeing funds to support them? Should school-based health centers be considered a safety net service, which would entitle them to a protected place at the managed care table? Or, can states create a supportive policy environment for school-based health centers while not mandating a flow of dollars to the centers?

Dilemmas confront the school-based health centers as well. Should they seek cost-based reimbursement from the federal government similar to that provided to federally qualified health centers (FQHCs)? Leaving aside the political viability of such an approach, would the gains secured by such a measure be short-term? Would the enhanced revenues be worth the price of federal standard-setting? Are the states and localities willing to trade program flexibility for greater financial security? Is there a realistic *policy* that supports school-based health centers that does not involve mandates?

On the morning of June 26, 1995, the National Program Office of Making the Grade convened a small group of federal and state health policy makers together with representatives from school-based health centers and managed care plans to review experiences in the development of relationships between school-based health centers and managed care organizations (see Appendix A, page 18 for participants list). In the afternoon session, meeting participants reconvened to consider the implications of this experience for public policies. The following pages summarize the conversations that took place during the morning and afternoon sessions.

Experience from the field: Three perspectives on building relationships between school-based health centers and managed care organizations.

The goal of the morning session was to allow representatives from three perspectives present at the meeting -- school-based health centers, state governments, and managed care -- to share their experiences in forging relationships between school-based health centers and managed care organizations.

School-Based Health Center Perspectives

For school-based health centers, negotiating with managed care plans is hard work that is not always rewarded. By all accounts, the school-based health center administrators find the task of negotiating with managed care providers challenging and burdensome. The results of the centers' marketing to the managed care plans have ranged from fee-for-service agreements between the centers and the plans to subcapitation contracts for primary care. And, although none of the school-based health centers have secured relationships with all of their communities' Medicaid managed care payers, the centers hold that as a goal and report varying degrees of progress toward that goal. But, it has not been easy and the results do not always seem to justify the effort (see also Appendix B, page 21, for individual profiles of school-based health center programs).

"We are starting to open up dialogue but there are major philosophical differences. For example, our school-based health centers do not function as a medical home 365 days a year, and this has been a stumbling block in our negotiations. In addition, the managed care organization says: 'I already pay a health center in my network to provide these services, why should I pay you?'"

-- Anita Wilenkin, Montefiore Ambulatory Care Network

"We had to develop a system of working with managed care. For example, we had to work out the best way to get authorizations from the plans to provide services to their patients. There are four very active HMOs in our area. We have been able to put this system together with two; we have not done anything significant with the others."

-- Bernice Rosenthal, Baltimore City Department of Health

"Our school-based health centers are in all of the primary care contracts that were negotiated by the health department with the six managed care organizations that serve Memphis, but that fact has not done the centers any good. The health centers have been promised, promised, promised. But, they still have no kids assigned to them for capitation from several of the plans."

-- Kathleen Johnston, Memphis/Shelby County Department of Health

"Health Start approached the multiple health plans uniformly and offered its full scope of services as a benefit to the plan. As a result, our school-based health centers are recognized as a primary care provider in each of the health plans' networks. The centers are not actually selected as primary care provider, but they are, in essence, a second source of health care for adolescents within the health plan."

-- Donna Zimmerman, Health Start, Inc.

"HMOs and primary care clinicians did not have a clue what we were doing in school-based health centers, so there was a tremendous amount of need to explain the centers to them. On the other hand, school-based health centers did not know what was going on in managed care."

-- Karen Hacker, Boston Health & Hospitals

School-based health centers attribute their successes in negotiating with managed care plans to the unique advantages they offer. The location and convenience of school-based health centers were identified as key reasons managed care plans were willing to consider a relationship with them.

"Our selling point is that we provide the service capacity at the school-based clinics. We provide something that can make a managed care plan excel."

-- Anita Wilenkin, Montefiore Ambulatory Care Network

"We made this work by saying: 'Look at the utilization of adolescents. They are not likely to go to the health plan for health care.' And the plans have responded: 'Yes, this makes sense for teenagers.' They simply will not get services unless they are convenient."

-- Donna Zimmerman, Health Start, Inc.

In some instances, the plans themselves have taken a broader, public view of health care delivery.

"HMOs in St. Paul are actually starting to look at how school-based health centers can be responsible for certain public health services in the community. They are moving away from thinking about services for their members to thinking about services for the school community."

-- Donna Zimmerman, Health Start, Inc.

The role of state government in helping school-based health centers negotiate with managed care plans has differed among the states. In Massachusetts, the state is considered a critical player in the development of relations between school-based health centers and managed care organizations.

"Without state pressure for change we would not be doing anything. When the state Medical Assistance office mandated linkages between managed care and school-based health centers as part of its contracting policy, it meant there was an open road ahead of us -- not an easy one, but an open one."

-- Karen Hacker, Boston Health & Hospitals

Despite contracts and agreements, most school-based health centers report a decline in revenue after the introduction of Medicaid managed care. Only one of the school-based health center representatives reported that her program -- the oldest program with the longest experience in billing -- has been able to maintain its previous levels of Medicaid revenues since the introduction of managed care. The experience of rendering care to patients for which others are being paid is frustrating to school-based

health care providers, particularly in those states that have expanded Medicaid coverage for school-aged children.

"We are beginning to see the erosion of fee-for-service funds. In the last two years, we've seen 15 percent denials for our Medicaid recipients who are in managed care."

-- Anita Wilenkin, Montefiore Ambulatory Care Network

"The grand total of \$8-13 per person per month for TennCare [the state's Medicaid managed care program] enrollees is a potential source of revenue for us, but we are realizing almost nothing at this point. Prior to TennCare, we realized more revenue and a higher return on our billable charges, and that was with a smaller percentage of kids who were eligible for Medicaid."

-- Kathleen Johnston, Memphis/Shelby County Department of Health

**Memphis/Shelby County School-Based Health Center
Billing/Reimbursement Activity, 1993-95.**

	1993 Medicaid	1994 TennCare	1995 TennCare (first quarter)
SBHC Services Billed	78%	60%	37%
Billed Services Paid	60%	40%	27%
Total Services Paid	47%	24%	10%

"We have made limited progress in Baltimore. Negotiations with managed care have not brought us a lot of money, but they have brought us some money. And, they have generated some nice relationships."

-- Bernice Rosenthal, Baltimore City Department Of Health

"Currently, there are no mandates for deliverables and there are no assurances for approvals. School-based health centers can go through the entire negotiation process, get the provider on the phone at the time of service delivery, and the provider still refuses to approve the patient visit. Even though the primary care clinicians (who serve as case managers) remain in a fee-for-service system -- so it is no skin off their backs to approve our services -- they still are not approving our services. They are fearful we will steal their patients."

-- Karen Hacker, Boston Health & Hospitals

"While we have not lost anything in terms of reimbursement with Medicaid managed care, it does not mean there are not issues. We have had to work out administrative complexities regarding EPSDT billing and managing multiple contracts with multiple networks of HMOs."

-- Donna Zimmerman, Health Start, Inc.

Despite difficulties, optimism persists. The opportunity to build partnerships and find sanction within the health care system has strengthened the school-based health centers' position within the community. Moreover, opportunities for the future hold promise.

"We need to establish a system with few barriers that allows students to be seen in a timely fashion. If we must work within a system that requires a tremendous amount of paper work, telephone calls, and things like that, access will decrease. I hope that in the next several years we can arrive at some sort of 'carve out' arrangement or develop a standard set of services that school-based health centers can provide to managed care patients with post-notification instead of pre-approval."

-- Karen Hacker, Boston Health & Hospitals

The Woodwork Phenomenon

One of the greatest challenges in designing financing strategies for school-based health centers is the need to project realistic service costs when there is a history of underutilization among school-aged patients, especially for adolescents. How do you control for the Woodwork Phenomenon?, queried Steve Rosenberg. As was seen in long term care, when services are made more convenient and accessible, costs are actually driven up by people "coming out of the woodwork" to take advantage of them.

Most of the health care financing representatives acknowledged that as school-based health centers increase access and utilization, costs for caring for school-age children could exceed projections and, therefore costs to managed care plans would exceed their capitation rate. And, at the state policy level, public expenditures might exceed planned expenditures on primary care for this age group.

But that is a narrow view, warned Alan Weil, Executive Director of the Colorado Department of Health Care Policy and Financing: "We really need to talk about costs in a global sense. If we could convince state policy makers to think about education system costs, employer and employee costs, and transportation costs, I would not assume an increase."

State Perspectives on School-Based Health Centers

Representatives from Colorado and Massachusetts, two states with major philosophical differences in their approach to public policy, described their strategies to support the development of school-based health centers. In the last decade Colorado and Massachusetts have promoted school-based health centers as a means of caring for school-age children, especially adolescents. In both states, the public health departments have encouraged the development of state financing policies. The states are also working to integrate school-based health centers into public and private managed care markets (see appendix C, page 25 for state profiles). It is the states' philosophies on the role of government, however, that accentuate their different approaches toward that goal.

Colorado's non-regulatory approach to its public policies has played an instrumental role in how the state has shaped its long-term financing strategies to support school-based health care.

"Mandates are not very acceptable in Colorado, even when they might be to everyone's best advantage; private market-based solutions are definitely what people favor."

-- Bruce Guernsey, Colorado School-Based Health Care Initiative

"If we had tried to mandate that all managed care plans contract with school-based health centers, we would be unsuccessful. Frankly, if we required them to contract, the plans would increase their rates to us and treat school-based health care like a carve out, and there would not be any coordination of services. We're more interested in a relationship than a carve out."

-- Alan Weil, Colorado Department of Health Care Policy and Financing

Massachusetts more frequently has used mandates and regulatory processes to implement policy goals:

"Initially we were approached by the school-based health centers and asked to make them a carve-out provider. But, we felt that because so many of the services they provide are primary care services it was important for the school-based health centers to be part of the managed care system. We felt it was our duty to help the school-based health centers integrate into the managed care system since we were forcing them to work within it."

-- Louise Bannister, Massachusetts Division of Medical Assistance

Efforts in both states to integrate the school-based health centers and managed care plans are in the early stages. In Massachusetts, there is greater urgency because all AFDC families will be enrolled in managed care plans by the fall of 1995. In Colorado, managed care is a growing part of the health care market; however, because managed care represents only 11 percent of Medicaid and upwards of 25 percent of the private market, the state is encouraging indemnity insurance as well as managed care plans to link with school-based health centers.

Both states have employed strikingly similar tactics in building relationships between managed care and school-based health centers. While still a "work in progress," the states' strategy has been to bring the parties together to educate them about each other's goals and objectives, and to explore opportunities for meeting common goals collaboratively. Excerpts from the state representatives' presentations follow.

On initiating a dialogue among public health, Medicaid, providers, and insurers...

in Massachusetts:

"The state has an on-going child and adolescent work group that has been meeting monthly for the past two years. The group consists of the Division of Medical Assistance, the Department of Public Health, providers, child advocacy groups, and other state agencies. We meet to establish a work plan and prioritize projects that effect children and adolescents in managed care. The HMO program has a similar child and adolescent work group that also meets monthly. That will be the mechanism for communicating with the HMOs."

-- Louise Bannister, Massachusetts Division of Medical Assistance

The state's efforts have been well received by the school-based health care providers.

"We've had a very unique relationship with the Departments of Medical Assistance and Public Health. It did not start in the most congenial way, but I

think we've become good friends over the last two years. I think we are beginning to see school-based health centers as part of an overall health care system -- and that is something toward which we all must strive."

-- Karen Hacker, Boston Health & Hospitals

...in Colorado:

"The problem in Colorado is that school-based health centers have not been integrated into the private health insurance system. Most of them have not done billing and have had a limited relationship with Medicaid."

The state health department decided to establish a relationship through managed care and other insurance carriers with Medicaid and to develop policy initiatives that increase access to health insurance for kids. And along those lines, find ways to promote school-based health centers as a cost effective delivery system"

-- Bruce Guernsey, Colorado School-Based Health Care Initiative

But, the "relationship" strategy is not without its challenges:

"In Colorado, we have a very competitive health care market with close to 190 health insurance plans and 3.5 million residents. So, it's not like we can approach only a handful and try to work with them. It has to be a long-term, consensus building process."

-- Bruce Guernsey, Colorado School-Based Health Care Initiative

On facilitating contractual relationships between school-based health centers and insurance carriers:

"When fostering contractual relationships between school-based health centers and insurance carriers, the best thing the state can do is to demonstrate that the centers can help the managed care organizations meet the quality and access standards that the plans will be held to in the future."

This year, we're hoping to develop a model contract for school-based health centers. And, at the same time, we hope to draft a model protocol for the coordination of services between school-based health centers and children's primary care providers."

-- Annie Van Dusen, Colorado Health Care Policy and Financing

"The HMO work group in Massachusetts is in the process of developing a universal communication form. The form will be in triplicate and all the school-based health centers are going to have to communicate with the child's medical home when they provide a service."

-- Louise Bannister, Massachusetts Division of Medical Assistance

On defining school-based health centers and developing quality standards:

"Since we are mandating that managed care organizations link with school-based health centers, we must give them some assurances about the quality of services that school-based health centers provide. So, we have developed quality standards for the school-based health centers. The Department of Public

Health will evaluate the sites to determine whether or not they meet the quality standards.

We have also done some quality measurements with primary care clinicians (PCCs) with regards to EPSDT. We are sending the message to PCCs that, if your kids, especially your adolescents, are not going to show up at their office for care, they should recognize that adolescents do show up at school-based health centers. So, school-based health centers can help PCCs meet their EPSDT goals."

-- Louise Bannister, Massachusetts Division of Medical Assistance

On broadening marketing efforts to include purchasers of insurance, such as individual employers and purchasing alliances:

"As I review school health services across the state, what is striking to me is the number of services that are being given in all schools, including affluent schools. It seems to me, we should broaden our marketing strategies to include commercial plans and large purchasers of insurance because we have many families who for various reasons are unable to get their children to their provider for sports physicals and immunizations."

-- Anne Sheetz, Massachusetts Department of Health

"In Colorado, we are seeing consolidation among purchasers. We think it now makes sense to explore relationships with large employers and with alliances. We want to talk to them about what school-based health centers could do as part of an employee benefits package."

-- Annie Van Dusen, Colorado Health Care Policy and Financing

On the limits of a state strategy that focuses on integrating school-based health centers with the insured market:

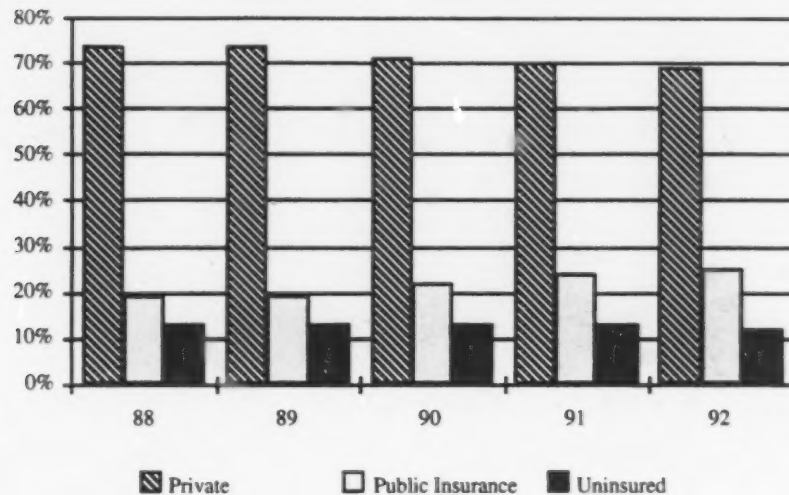
"We are just finishing the analysis of a survey of 2,000 employers and 2,000 households in Colorado. We have learned that about 16 percent of Coloradans are uninsured, and that 15 percent of all children in the state are uninsured. This is important to the extent that school-based health centers are located in neighborhoods where there is a disproportionate number of both uninsured and Medicaid enrolled students.

Another important factor when considering strategies for long-term financing of school-based health centers is that 90 percent of uninsured children have at least one working parent. But, our data show a decrease in employer-based health insurance for children, an increase in Medicaid enrollment among children, and no change in uninsurance among children (see national insurance status figures, page 10). I think that impending Medicaid cuts will cause an increase in the uninsurance rates among kids and a decrease in the number of children that will be covered by Medicaid.

In Colorado, we are grappling with the fact that incremental health insurance reforms -- while very good policy -- are not going to make health insurance affordable to low-income, working families."

-- Annie Van Dusen, Colorado Health Care Policy and Financing

**Health Insurance Status of Children Under Age
Eighteen, 1988-92**



Source: Newacheck et al., Children and health insurance: an overview of recent trends. *Health Affairs*, Spring 1995, 244-254.

A Managed Care Perspective

Sandra Maislen, Vice President for Professional Affairs at Boston's Neighborhood Health Plan (NHP) and one of the two managed care representatives at the meeting, knows school-based health care: twenty-two of the state's 31 school-based health centers are under direct management of NHP's primary care provider sites. "School-based health centers have always been a part of our network," says Maislen. So much so that NHP has created an internal carve out from reserve funds for school-based health center services. The strategy was purposeful: "We're going to collect information and data and then go to the state and say we need our premium increased to do this," reported Maislen.

However, NHP's support of school-based health centers is not unqualified. Maislen raised the following questions, which she hopes data collection efforts can help address:

- *How do you define your school-based health center product? "What is it exactly that you are asking the HMO to buy? Who is providing the service, and do those providers meet the HMO standards for primary care?"*
- *How do you cost out the school-based health center product? "Most school-based health centers have never billed for services, which means these costs have not showed up anywhere. Those costs are not in my Medicaid premium because Medicaid never paid for those services in the state of Massachusetts."*

- *How does the HMO pay for school-based health center services? "I do not believe in capitating providers who can not take risk. So far, I have not found a school-based provider that can accept risk."*
- *How do you resolve important clinical management issues between the centers and the HMOs? "Where does the medical record reside? Where does EPSDT documentation reside? Is a nurse practitioner equivalent to an adolescent medical doctor or a pediatrician? For my plan, we don't allow nurse practitioners to be primary care providers. They can only be part of a team."*

Maislen echoed the importance of marketing school-based health centers' strengths to managed care providers: "School-based health centers provide customer-focused service. They can help HMOs perform better and achieve quality standards. For example, NHP can say: 'We have a 95 percent compliance rate in EPSDT.' That's an incredibly powerful marketing tool to sell school-based health care to an HMO."

With the meeting's intense focus on managed care challenges and frustrations, did Maislen feel like the enemy? "Managed care, particularly HMOs, get a bad rap," she said. "The HMOs have been excluded from the Department of Public Health activities, and then get blamed for not participating in public health initiatives."

Public health and Medicaid officials in Massachusetts are trying to remedy this situation through regularly scheduled work groups of providers and state policy makers. Participants discuss managed care issues related to children and adolescents. "It's been really great having a table to sit at and having people to talk to. It's an unusual scenario having the state Medicaid office working collaboratively with HMOs," said Maislen.

Towards Consensus on Public Policies to Support School-Based Health Centers

The goal of the afternoon session, which was facilitated by health care finance consultant Steve Rosenberg, was to reach consensus on a series of issues fundamental to financing school-based health centers. These issues, some of which had been raised by state representatives earlier in the day, included defining the school-based health center service package, assessing the desirability of a "carve out" for the centers and the possibility of mandating cost-based reimbursement, and identifying critical data needs.

Defining SBHC Services

There was more diversity than consensus among the responses to Rosenberg's question: "How should we define the school-based health care delivery model: as outpatient services, public health, preventive care, or a medical home?"

"School-based health centers fit into all those categories. The federal Healthy Schools, Healthy Communities school-based health center grantees are outpatient services; they are required to do case management, and they could be considered medical homes."

-- Jane Martin, DHHS Bureau of Primary Health Care

"In Maryland, we are moving more towards the model of school-based health centers as medical homes."

-- Susan Tucker, Maryland Medical Care Policy Administration

"For some kids, a school-based health center may be their primary care provider. Or, a center may provide acute care services during school hours for a child who has a primary care provider somewhere else. School-based health centers also have a public health perspective; they provide services to a population, not just to a string of disconnected individuals."

-- Mary Applegate, New York Department of Health

"We see school-based health centers as an opportunity to further the global goal of expanding medical services to areas that are underserved. We will look at opportunities for contracting with them as a secondary home -- as a medical home."

-- LaVerne Smith Boykin, Prudential Health Plan

"School-based health centers are a venue for providing public health services. I have started referring to them as prevention and early intervention providers because I do not know how to define the nature of what they do. I will be concerned if school-based health centers are pushed into the medical model."

-- Karen Hacker, Boston Health & Hospitals

"If we look at the history of school-based health centers, we see that the communities where the centers are located have had a key role in defining the scope of services offered in those clinics. So, every school-based health center has a slightly different program."

-- Polly Harrison, Maryland Department of Health and Mental Hygiene

"We need clarification on core definitional issues around what ought to be the services that we are providing to children under Medicaid, or under some larger public health or social model, that represent an optimal set of arrangements."

-- Rachel Block, DHHS Health Care Financing Administration

Developing a Uniform Standard

Despite the historical significance of community-defined service models, many of the representatives suggested that a standardization of the school-based health center model will be forthcoming, particularly if the centers are to participate in the mainstream health care financing mechanisms.

"The Healthy Schools, Healthy Communities grantees will have some uniformity among them because of the requirements we have placed on them."

-- Jane Martin, DHHS Bureau of Primary Health Care

"We currently are developing a model that we hope all of the school-based health centers in New York will follow. There is diversity among the models now, but we hope there will be less of that eventually."

-- Mary Applegate, New York Department of Health

"In Maryland, we have been trying to push school-based health centers up the ladder to becoming medical homes."

-- Susan Tucker, Maryland Medical Care Policy Administration

**Funding
Stability and
Preserving
the Mission
of SBHCs**

"Around 1972, the U.S. stopped looking at neighborhood health centers as a social model of health care and started looking at them as a medical model. This change was made so that health centers could bill Medicaid.

We made the change by having the predecessor of the Bureau of Primary Health Care define the Bureau's Common Reporting Requirements. These requirements set the standards for health centers in such areas as: scope of service, budget allocations, productivity, and how services are delivered. These rules essentially defined a medical model and did not support a broader social approach to care.

The question on the table now is: can we write the rules for school-based health centers so that we secure federal reimbursement dollars without narrowing the model so drastically that we take away from the unique model, access, services, and all the other reasons that gave rise to these centers?"

-- Steve Rosenberg, Rosenberg & Associates

Is it possible, asked Rosenberg, for school-based health centers to avoid the undesirable but necessary choice that confronted community health centers in 1972? Will school-based health centers be forced to abandon their community-driven, social model of health care to secure a place within the current reimbursement system? Will we have to burn the village to save it? The alternatives seem few. Consider this scenario offered by Rosenberg:

"Assuming the average cost of a comprehensive school-based health center serving a school with 1,000 students is \$200,000, and all of the students are insured, the center would need a \$16 per member/per month (pm/pm) rate to operate in a fully capitated environment."

Most panelists agreed that the market would not support such a rate. What, then, are the viable alternatives?

Rosenberg offered the possibility that the Omnibus Budget Reconciliation Act of 1995 might include provisions for a Medicaid block grant program, which could include a series of directives concerning use of Medicaid funds. One such directive might involve a federally mandated cost-based reimbursement (or carve out) for a defined transition period for community health centers and other federally qualified health centers (FQHCs). Rosenberg asked meeting participants if school-based health centers should be given the statutory right to be paid costs from all financing mechanisms -- as are FQHCs -- during this transition to full-blown managed care? Under such a scenario, school-based health centers essentially would operate as an independent system of care and would not be required to seek prior authorization when serving managed care patients.

The advantages of such an arrangement, according to Rosenberg, would be two-fold: 1) if the carve out were for a transitional period, that time could be used to establish a historical cost and data record, which is needed to create a managed care reimbursement rate structure; and 2) the carve out would give school-based health centers greater leeway in negotiating a role in their community's managed care systems.

A "carve out" by any other name
Among meeting participants, there were almost as many definitions of the term "carve out" as there were participants.

Mary Applegate suggested that a school-based health center is considered a carve out when *"its services are not part of the capitation and the school-based health center can bill directly and get paid directly."*

Steve Rosenberg broadened that definition: *"No gate keeping is a form of carve out. Carving out \$2.00 pm/pm to pay for Rhode Island transportation [as an example] is another form of carve out. And mandating contracts between managed care and the school-based health centers is a form of carve out."*

"So, any sort of preferential treatment is your idea of carve out," concluded Mary Applegate.

A federal carve out, however, is not without its drawbacks, warned Rosenberg. Defining the functions of school-based health centers through a federal statute would require all programs desiring Medicaid reimbursement under a carve out to meet federal eligibility standards. Another, perhaps unintended, consequence of a federal carve out might be exponential growth in the number of school-based health centers -- due not to an interest in serving children and youth, but to the attractiveness of the enhanced Medicaid reimbursement structure.

Many meeting participants opposed a federal carve out for school-based health centers either on the grounds that it was not politically viable, or that a carve out would have untoward consequences. State financing officials, especially, reminded Rosenberg that a federal definition for school-based health centers is inconsistent with the community-driven mission of school-based health centers. Moreover, the carve out approach seems inconsistent with future directions in the health care system. But, Rosenberg warned, if school-based health centers refuse to play the federal reimbursement game, they will be left to rely primarily on local dollars.

"Why pick out school-based health centers, which represent a relatively small part of our primary care system, and give them special consideration over all the other traditional community providers that are at our door? It is not good public policy to force states to purchase and pay certain rates when they have limited budgets. Special considerations for providers should be limited and used cautiously."

-- Barbara Frankel, New York Department of Health

"The more you carve out, the less you have. Why have a managed care program at all if you keep continuing to carve out services?"

-- Susan Tucker, Maryland Medical Care Policy Administration

"A carve out is inconsistent with the direction in which we are trying to move. Why should we force school-based health centers who had the intelligence to not set up fee-for-service billing systems to move in that direction just so they can then move in the opposite direction?"

-- Alan Weil, Colorado Department of Health Care Policy and Financing

"Unless there is a specific statutory reason for the Health Care Financing Administration to deal with some services and/or providers differently than others, then our basic mantra is 'flexibility to the states.' Even if they were undertaken with the best intentions, none of the federal FQHC experiments in creative financing have led to much good."

-- Rachel Block, DHHS Health Care Financing Administration

However, federal and state public health program administrators were more intrigued with the notion of a carve out:

"A fairly broad federal push for school-based health care would be helpful. Family planning has benefited from required preferential treatment, so it probably would be good for the future of school-based health care also."

-- Mary Applegate, New York Department of Health

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"School-based health centers need a transition period as they go from a fee-for-service Medicaid system to a managed care system. One of the best ways to do that is through cost-based reimbursement for an interim period."

-- Lynda Honberg, DHHS Bureau of Primary Health Care

The school-based health care providers were ambivalent:

"I think school-based health centers should choose to invest their energies in trying to get themselves into the managed care system rather than out of it. I'd rather expend the political energy trying to figure out how to get HMOs to offer a nice package of services for adolescents."

-- Donna Zimmerman, Health Start, Inc.

"There is something to be said for this carve out idea. If I had three years of federal Medicaid reimbursement protection, I would be able to put money aside and then use it to keep my clinics whole when managed care starts to squeeze them out."

-- Anita Wilenkin, Montefiore Ambulatory Care Network

A Conservative Culture

The reluctance of school-based health centers to embrace cost-based reimbursement for their services reflects, according to Rosenberg, a conservative community.

"I meet a lot of rural physicians and hospital administrators to whom I will say: 'You guys are leaving hundreds of thousands of dollars on the table. You just have to do this, this, and this and you can get another half a million dollars a year.' And they respond: 'No, thank you. That's not the responsible way to behave. The federal deficit begins with us.' Their community values are such that they would rather cut services than 'go on the dole.'"

It seems that the school-based health care community shares similar values with the rural health community. Both groups demonstrate a certain caution and conservatism toward the federal government. Only time will tell whether or not that choice is the right one."

Challenges Ahead

In the absence of federal protections for school-based health centers, the movement will most certainly reach a critical juncture. This challenge was posed:

"The opposition to federal carve outs and cost-based reimbursement by the centers and the inability of managed care contracts to cover total operating costs -- if and when contracts are successfully negotiated -- presumes some other source of public funding will fill the gaps. Where will it come from?"

I see a disconnect between today's political realities and the rational health policy that we would all like to see. I'm hearing from the states that they are unable to intervene more forcefully with managed care with regard to school-based health centers. They do not make centralized decisions. Right now, states are telling us: 'let's let the market work.'"

But, I thought Sandra Maislen of Neighborhood Health Plan pointed out the vulnerability of school-based health centers very clearly. Yes, school-based health centers want to contract with managed care, but it is not happening. When it does happen, it is for a reimbursement rate that is way below a center's total costs."

-- Rush Russell, The Robert Wood Johnson Foundation

There was widespread recognition that school-based health centers have been anomalies in the mainstream health care system, and that the need to pursue marginal public health dollars will always be a reality for school-based health care providers. Many participants agreed that local and state dollars will continue to be important sources of revenue. Essential to the pursuit of these dollars, said Rosenberg, is the building of a political constituency sufficient to ensure a place at the bargaining table when difficult choices must be made about the division of diminishing local health dollars among community providers.

"School-based health centers will never be fully reimbursable through insurance alone. Much of what the centers do is not reimbursable. And, as long as we have large populations of uninsured in our schools, it is going to get worse."

-- Karen Hacker, Boston Health & Hospitals

"School-based health centers have a public health perspective, so they recognize that they will always need other dollars."

-- Bernice Rosenthal, Baltimore City Department Of Health

Many states, recognizing that their large Medicaid expenditures are not benefiting adolescents, have committed both federal and state dollars to school-based health programs. But, can the states' parallel support of both school-based health care and managed care co-exist?

"If you assume that state governments are reasonable and responsible, then you have to assume that they will be looking for ways in which these two policies, with their natural tensions, can be reconciled."

-- Julia Graham Lear, Making the Grade National Program Office

Critical Next Steps

As Congress moves to make significant changes in public health policies, programs, and funding, school-based health centers have recognized the need to move quickly. Suggestions for immediate follow up to this meeting included:

Data Analysis. The need for supportive data was voiced continually throughout the day, particularly as it relates to understanding utilization and costs to provide services:

"Data can help managed care organizations determine what the possibilities are for furthering their relationships with school-based health centers. Right now, those possibilities are largely unknown."

-- LaVerne Smith Boykin, Prudential Health Plan

"The way states operate, they are not going to pay for something if they do not know how much it costs. There are still huge gaps in terms of any real data on utilization."

-- Bernice Rosenthal, Baltimore City Department Of Health

"Given how successful and how strong these programs are, the dilemma is that we do not have the data to prove it. If school-based health centers need technical assistance, it is in the area of data collection and analysis."

-- Barbara Frankel, New York Department of Health

"We do not have any idea what it costs on a capitated basis to provide true access to care for adolescents. All we currently are doing is locking in reimbursement rates based on a history of under-service."

-- Steve Rosenberg, Rosenberg & Associates

"We have a tremendous need for data that demonstrate effective chronic disease management through reductions in emergency room use, hospitalizations, days missed in school, etc."

-- Anne Sheetz, Massachusetts Department of Health

"What are the costs of school-based health care programs? What are the effects of these programs on employees and employee absenteeism? The effects on costs of self-insured plans?"

-- Alan Weil, Colorado Department of Health Care Policy and Financing

"We have an enormous amount of data that tells us how kids use school-based health centers. I do not know that private pediatricians or hospital clinics for adolescents have any more information than we do. But, we are held to a higher standard than most other providers of care to school-aged children."

-- Linda Johnston, DHHS Maternal and Child Health Bureau

Other suggestions for technical assistance and follow up included:

Electronic billing system. An efficient and effective electronic system billing system is universally desired by school-based health centers and managed care plans. A large number of centers are using School HealthCare On-Line!!!, which captures registration and encounter data; however, frustration is high with the system's inability to communicate with sponsoring institutions' mainframes and generate electronic bills.

Technical assistance to providers in negotiating with managed care plans. The waters are deep and the experience is limited. School-based health centers want guidance on negotiating with managed care plans. Model contracts would be helpful.

Assistance in quality in access standards. School-based health centers want to be able to demonstrate that they can help insurers achieve quality in access standards for both Medicaid and general populations.

Site visits by federal officials. School-based health center administrators and advocates would like to see more federal officials conducting site visits to school-based health centers.

A roundtable meeting of managed care staff (policy makers, medical directors) from prominent HMOs and Medicaid officials to continue the dialogue that was begun in this meeting. Meeting participants also think it would be a good idea to broaden the dialogue to include purchasers of insurance, self-insured employers, and the Federal Employee Health Benefits Plan.

Advocacy guidance. School-based health centers believe they need guidance in how to affect change at the state level.

APPENDIX A -- PARTICIPANTS ROSTER

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APPENDIX B - LOCAL PROFILES

Baltimore City Health Department

The Baltimore City Health Department sponsors 10 of the city's 16 school-based health centers. The health department's centers are located in five high schools, three middle schools, one elementary, and one K-8 school. Of the estimated 6,000 students served by the 10 centers, 35-40 percent are Medicaid-insured. Maryland Medicaid beneficiaries may choose as their managed care provider either 1) a Maryland Access to Care (MAC) primary medical provider, which the state reimburses for case management via an enriched fee schedule, or 2) a health maintenance organization, to which the state pays a monthly capitated rate. Medicaid-insured students who attend schools that have health centers may select their school's center as their primary medical provider. Under this arrangement, the health department may bill Medicaid for all covered services. For students whose families enroll in a HMO, reimbursement for their care will depend upon individually negotiated agreements with the HMOs. The only exception is family planning services which are required by law to be paid to out-of-plan providers.

The proportion of Medicaid students enrolled in HMOs is growing quickly; aggressive marketing tactics by the four competing HMOs are compelling large numbers of families into prepaid plans. Currently, an estimated 65 percent of Medicaid-insured students in Baltimore are enrolled in managed care plans. During the past school year, 56 percent of visits by Medicaid beneficiaries to the health department's school-based health centers were denied payment because the patient was enrolled in an HMO. As a result, the Baltimore City Health Department has seen Medicaid patient revenues collected by the school-based health centers fall by one-third over the last two years, and officials expect the decline to continue. Patient care revenues, which exceeded \$150,000 in 1993, will be less than \$100,000 in 1995. So far, local public health dollars have covered the shortfall, but continued expansion of school-based health centers will require negotiated relationships with all of Baltimore's Medicaid managed care plans.

The health department's school-based health centers currently are funded through what is essentially a global budget that is jointly administered by the city's health and education departments. More specifically, the school-based health centers are partially funded from the revenues that accrue to the city when it bills Medicaid for services provided under Individual Education Plans (IEP) and Individual Family Service Plans (IFSP) required by federal law for children with disabilities. In addition, the more recent health centers are funded, in part, from the sponsoring schools' individual budgets.

Recently, the health department negotiated a fee-for-service billing arrangement for EPSDT and immunization services with one of the city's four Medicaid managed care plans. Acute care and other medical services are reimbursed by the plan only if the patient cannot be seen by the HMO on the same day. A referral plan and service tracking system have been established to assure continuity and quality of care. Although the scope of services and payment schedules outlined in this first contract are limited, the health department hopes this arrangement will lead to negotiations with other plans.

Boston Dept. of Health and Hospitals

Eight of Boston's thirteen school-based health centers are sponsored by Boston Department of Health and Hospitals (DH&H), which opened its first center in 1989. The centers, each located in city high schools, provide a variety of services to adolescents, including acute care, health education, diagnosis and treatment of minor illness, physicals, STD testing and treatment, mental health counseling, laboratory and chronic disease screening. Funding for the \$1.1 million program comes from federal, state, and local public health grants as well as patient care revenue from a city indigent health care pool.

Boston Department of Health and Hospitals' school-based health centers serve a large proportion of uninsured school-age children. While percentages vary from center to center, half of the student enrollees have no health care coverage. Among students with insurance, 20 - 25 percent are enrolled in Medicaid, 13 percent are in commercial pre-paid plans, and ten percent have private fee-for-service insurance.

In 1992, HCFA granted Massachusetts a 1915(b) waiver of the federal Medicaid "freedom of choice" provision, enabling the state to move its Medicaid population into managed care plans. Eligible Medicaid recipients choose either a capitated pre-paid plan, i.e. HMO, or a primary care clinician (PCC) who provides case management on a fee-for-service basis. To date, less than 30 percent of enrollees have joined HMOs. In an effort to encourage relationships between school-based health centers and managed care plans, the state Medical Assistance Division requires that participating HMOs establish a relationship with school-based health centers in their service area. There is no such requirement for the more than 1,300 primary care clinicians statewide.

According to the DH&H program administrators, the introduction of Medicaid managed care has had a profound impact on the delivery of school-based health care. The fundamental values of school-based health care -- to provide students access to comprehensive, appropriate care, to see all comers regardless of ability to pay -- is compromised by policies of the managed care plans. How are centers to provide services expeditiously when time consuming pre-authorizations are required, or when the authority to render service is denied? Is it the responsibility of the school-based health care sponsor to deliver the care regardless, or to respond to each of the various plans' and providers' requirements? To date, DH&H has worked with four HMOs serving the majority of Medicaid recipients with varying results. One HMO has agreed to waive authorization for primary care services; reimbursement is awarded to DH&H on a low fee-for-schedule basis. Another has granted the centers approval to render only urgent care. A third has asked to be contacted should their clients seek care at the school-based health center so to schedule appointments with the HMO. The fourth, which functions as an independent physician organization, requires arrangements to be made with its individual providers, a time-consuming, expensive task for the school-based health center program administrators.

While managed care, so far, has been an administrative burden for the school-based health centers, a financial impact is likely to be felt in the months ahead. DH&H officials fear that existing sources of funding from local and state public health dollars are likely to be absorbed in impending health care reform efforts. Patient care revenue for services delivered to Medicaid-insured students, heretofore limited, will become vital to the continued existence of the DH&H

network of school-based health centers. To this end, DH&H is seeking primary care exemptions from PCCs for certain services. The outcome of this strategy remains uncertain.

**Health Start
Inc., St. Paul,
Minnesota**

Since opening its first school-based health center in St. Paul in 1973, Health Start, a community-based maternal, child, and adolescent health care corporation in Ramsey County, Minnesota, has expanded into all seven of the city's high schools. Nearly 40 percent of all high school students use the health centers at least once during the school year. Nearly 50 percent of student users are eligible for Medicaid, 25 percent are uninsured, and 25 percent have some form of private indemnity insurance or are enrolled in a commercial health maintenance organization.

In 1990, facing caps on state grant support, Health Start turned to third-party reimbursement to expand the resources of its school-based health centers. For nearly 20 years, Health Start had sponsored community-based services for low-income women and children and had secured Medicaid reimbursement for some of this care, so it was able to draw on this prior experience when it began negotiating relationships between school-based health centers and insurance agencies. In the five years since Health Start began aggressively billing third-party payers for services delivered at school-based health centers, it has realized \$100,000 annually in reimbursements that support its school-based health centers.

In 1993, as Ramsey County's mandated Medicaid managed care program took shape and private managed care plans expanded, Health Start officials understood that its patient care revenues could be seriously affected. With 75 percent of St. Paul students expected to be covered under prepaid managed care plans, the potential to be locked out of a large share of health care dollars was very real. In response, Health Start initiated negotiations with managed care plans to secure clinical coordination and continued reimbursement for services to both publicly and privately insured students.

Today, Health Start has formal agreements with the four managed care plans that serve Medicaid clients, as well as one commercial plan. While the responsibilities of Health Start's school-based health centers vary from plan to plan, reimbursement is rendered under a fee-for-service arrangement, although at lesser rates than were paid under the former Medicaid program. Despite lower fees, Health Start reports no decline in patient revenues, primarily because of increased billing activity. Under the managed care demonstration program, Medicaid eligibility was expanded to a greater number of low-income children, increasing the number of insured students seen in the centers. In addition, the state's policy of sending an explanation of benefits to the home -- which prevented providers from seeking payment for minor-sensitive services -- was discontinued by the plans to protect clients' confidentiality, thus expanding reimbursable services.

The shift to Medicaid managed care has increased administrative costs for Health Start: not only must it establish relationships and negotiate with health care payers, but the administrative expectations associated with the primary care gatekeeper role is significantly greater than that required by previous fee-for-service arrangements.

**Memphis and
Shelby
County
Health
Department,
Tennessee**

Prior to the Memphis and Shelby County Health Department's establishment of two school-based health centers in the late 1980s, Tennessee had limited school-based health care and school nursing services. For five years, the health department funded supported its two high school-based health centers with a combination of private foundation support, local health department dollars, and after a long struggle, contributions from the state Medicaid program.

Approximately 60-80 percent of students at each of the two sponsoring schools were eligible for Medicaid. In 1994, however, with the implementation of TennCare, Tennessee's mandatory Medicaid managed care program, the health department suffered a serious setback in its efforts to establish a system of reliable Medicaid reimbursements.

In the first six months of TennCare, despite the fact that 80-90 percent of students are eligible for the program, each school-based health center saw its Medicaid revenues decline from about \$16,000 to \$2,500. Since that time, the health department has initiated extensive negotiations with the managed care plans on behalf of its school-based health centers as well as its other primary care services. At present, six managed care plans are enrolling Memphis' TennCare beneficiaries; five plans have agreed to collaborate with the health department and share capitation dollars, either through a per member per month sub-capitation rate (ranging from \$8-13) or traditional fee-for-service reimbursement. However, while the two clinics together serve about 1,600 students, and approximately 1,200 to 1,500 students from the two schools are enrolled in TennCare, the school-based health centers have had only a handful of students assigned to them for capitation. One plan is a self-contained HMO that does not contract with any outside providers.

While evolving relationships with the plans may lead to improved financial support, evidence continues to suggest that a smaller proportion of services to TennCare-insured students are being paid for than was the case under the previous Medicaid program, and at a reduced rate. Thus, revenues, which were limited to begin with, have fallen sharply.

**Montefiore
Ambulatory
Care
Network,
New York
City**

The Montefiore Medical Center, through its Ambulatory Care Network, opened its first school-based health center in 1980 as part of a New York State Department of Health demonstration program. During most of the 15 years that followed, the Ambulatory Care Network did limited patient billing because most students were either uninsured or Medicaid insured, and the Medicaid rate was thought to be too low to cover the cost of billing. In 1992, the state changed its Medicaid regulations and allowed school-based health centers to bill at the service rate of its back-up facility (\$70-\$110 compared to the previous school-based rates of \$34 and \$23). With this rate increase, the Ambulatory Care Network opened additional school-based primary care centers and hired a full-time medical director to oversee the program. Today, the network administers seven centers in three districts in the Bronx, including five elementary schools and two high schools. Two more elementary school centers are slated to open this fall.

Medicaid managed care, which has been in place in New York City since the mid-1980s, began to expand rapidly in the early 1990s. In 1991, both the state and city established a goal of 50 percent enrollment in Medicaid managed care by 1997. This year, New York City has requested a 1915(b) waiver to mandate

managed care for most Medicaid beneficiaries. For its part, the state has filed for an 1115 waiver. These policies, according to Ambulatory Care Network officials, will jeopardize the survival of its school-based health centers, which rely on Medicaid revenues for primary care services provided to Medicaid-insured enrollees. Currently, the centers' Medicaid population ranges from 30-75% patients.

At present, 15 percent of students seen by the network's school-based health centers are enrolled in a managed care plan. Accordingly, the increasing number of denials for Medicaid fee-for-service billing for visits to the network's school-based centers is raising concerns. Although the network has established provider contracts with two of the nine managed care plans serving the Bronx, nine in ten visits from managed care enrollees are "out of plan" and non-reimbursable. The network estimated a loss of \$30,000 in Medicaid revenues for services provided to managed care enrollees in 1994.

Attempts by the network to establish clinical and fiscal relationships with managed care plans have met with limited enthusiasm. Because the school-based health centers serve only those students enrolled in sponsoring schools, managed care representatives are concerned that dividing primary care responsibilities for families between school-based health centers and other providers will jeopardize coordination of care. In addition, managed care plans are dubious about allocating health care dollars to school-based health centers, either through sub-capitation or fee-for-service reimbursement, for services they believe are already available and billed in capitation to their own providers.

The need for coordination and negotiations between Medicaid managed care payers and the network is becoming increasingly important as both New York City and New York State seek to mandate managed care for Medicaid beneficiaries. The loss of the network's enhanced Medicaid fee-for-service reimbursement rate could force the network out of the school-based health center business.

APPENDIX C - STATE PROFILES

Colorado

School-Based Health Centers: *There are 26 school-based health centers in Colorado, which primarily are supported by federal dollars from the Bureau of Primary Health Care, the Mental Health block grant, the Substance Abuse block grant, and private foundations. A few school-based health centers, sponsored by community health centers, also receive limited third-party reimbursement, including Medicaid. State grant support for school-based health centers totals \$175,000 in MCH block grant funds.*

Medicaid Managed Care: *90,000 school-age children are enrolled in Medicaid in Colorado. Since 1982, the Primary Care Provider (PCP) program has enrolled 50 percent of Medicaid beneficiaries with PCPs, which are reimbursed for gate-keeping functions on a monthly capitated basis. Services exempt from PCP approval are family planning, emergency care, mental health, and care given to foster children. Colorado has not applied for an 1115 waiver, but still expects Medicaid managed care to grow at a pace similar to that of the private managed care market (about six to eight percent annually). Medicaid patients who do not choose a PCP are assigned to an HMO, if one is available in their area. To date, the state has negotiated Medicaid contracts with six managed care plans, and two more contracts are under development. Currently 89 percent of the state's Medicaid beneficiaries remain in PCP-based fee-for-service arrangements.*

Under the auspices of the Making the Grade planning grant, the Colorado Department of Public Health and Environment established a policy and finance task force of private and public sector leaders in health care finance to explore strategies for securing third-party reimbursement for school-based health centers. Given the state's anti-regulatory climate, the task force recognized that mandating relationships between school-based health centers and managed care organizations was an unlikely policy option; fostering partnerships between the two will require time and the building of trust. To facilitate the managed care/school-based health center relationship, the state task force produced a number of support documents with input from insurance companies and health care plans:

- A school-based health center benefits package was developed as a guideline for local program development;
- A school-based health center cost analysis (based on data from Denver school-based clinics) was conducted to inform health care payers about operating expenses (per type of service) and costs per enrolled student;
- A set of accountability measures was drafted as a requirement for contractual arrangements with insurers;
- A market share analysis was initiated using school enrollment data matched with Medicaid and selected managed care organizations; and
- A Medicaid "white paper" was drafted jointly by the departments, which outlined barriers, issues, and responsibilities. A decision memo has gone forward to the director of the Department of Public Health and Environment.

These and related activities are intended to facilitate productive relationships between managed care organizations and the state's network of school-based health centers that will result in revenue going to the centers from private and public payers.

Massachusetts

School-based health centers: The State of Massachusetts began its grant support for school-based health centers in the mid-1980s. In 1993, with about \$5 million from a new tobacco tax, the state increased the number of school-based health centers from 10 to 31. State grant funds for school year 1994-95 total \$2.3 million. Additional funds are provided through local sponsoring agencies, private contributions, and third-party reimbursement, including Medicaid. Many school-based health centers in Massachusetts operate as satellite clinics for other providers, such as community health centers and hospital outpatient clinics.

Medicaid Managed Care: Medicaid managed care was established in Massachusetts in 1992 under a 1915(b) waiver. In addition, the state was recently granted an 1115 waiver. Medicaid beneficiaries must select as their managed care provider either an HMO or a primary care clinician, who serves as a gate-keeper and case manager. Currently, the state's Medicaid program contracts with 12 HMOs. One in four Medicaid beneficiaries eligible for managed care is enrolled in an HMO.

The implementation of the Massachusetts Medicaid managed care program more than two years ago raised concerns about the impact on child and adolescent services. Among those concerns was the potential for negative impact on school-based health centers and their role in providing access to children and adolescents needing primary and preventive health services. The State Division of Medical Assistance and the Department of Public Health have been working in partnership with school-based health centers and the state's 12 Medicaid HMOs and primary care clinicians to integrate school-based health centers into managed care. The state agencies are pursuing a number of strategies to promote relationships (both fiscal and clinical) between managed care plans and school-based health centers:

- State standards for school-based health centers, developed jointly by Medicaid and the Bureau of Family and Community Health as a condition of state funding, provide assurances to managed care plans regarding the quality of care rendered in school-based settings.
- The state Medicaid office requires managed care plans to develop linkages with school-based health centers. Medicaid is also promoting the usefulness of school-based health centers in assisting HMOs meet EPSDT requirements.
- Two strategies employed by the state to educate managed care providers about school-based health centers include monthly roundtable meetings with HMO representatives and a statewide outreach system that targets more than 1,300 primary care clinicians.
- Training and technical assistance is provided jointly by state Medicaid and public health staff to health benefits managers regarding the availability of school-based health centers. Technical assistance is also provided to school-based health centers to help maximize their billing capacity.

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